DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 8/07/10

PRINTED: 06/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING _____ B. WING _____	06/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH COUNTY HEALTH CARE CENTER	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On June 21 - 23, 2010 the annual recertification survey and investigation of complaints # TN00025895, 25022, and 25636 was completed. No deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview the facility failed to assure Nasal Cannula (type of oxygen delivery) tubing was changed timely for three resident's (#15, #16, #19) of twenty-seven residents reviewed. The findings included: Resident #15 was admitted to the facility on March 29, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, and Hypertension.	F 328	F328 Residents found to be affected by the deficient practice were identified. Residents #15, #16, #19 cannuals were replaced. No harm was noticed to the identified residents. Residents using cannula were checked and no other cannulas were found outdated. Residents who have the potential to be affected by this deficient practice will be identified by need for product usage. The DON or SDC will inservice the nursing staff on changing of nasal cannula at least weekly, per policy (07/13/10 and ongoing). The Director of Nursing (DON) or Assistant DON or weekend RN supervisor will check residents using nasal cannual's to assure they have been changed. Any cannula's found not changed will be reported to the DON and the Center PI (QA)Committee. Audit results will be monitored through the Center PI (QA) Committee. The Committee will review reports, make recommendations and instruct/give direction to assure compliance Reporting to the PI committee will be accomplished/repeated each 30 days for a minimum of 90 days and/or until zero error reported.	08/06/09

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 328	Continued From page 1 Medical record review of the Recapitulation Physician's Orders for June 2010, revealed, " ...O2 (oxygen) at 2L/MIN (two liters per minute) VIA (by) NASAL CANNULA..." Observation on June 21, 2010, at 9:35 a.m., in the resident room revealed, an oxygen concentrator in the on position delivering oxygen to the resident at 2L/MIN by nasal cannula. Continued observation at this time revealed no date on nasal cannula tubing. Interview with Charge Nurse # 1 on June 21, 2010, at 10:17 a.m., in the resident room confirmed, there was no date on the nasal cannula tubing to indicate when the tubing was last changed. Resident #16 was admitted to the facility on January 19, 2001, with diagnoses including Congestive Heart Failure, Osteoarthrosis, and Hypothyroidism. Medical record review of Recapitulation Physician's Orders for June 2010, revealed, " ...O2 (oxygen) at 2L/MIN (two liters per minute) PER (by) N/C (nasal cannula)PRN (as needed)..." Observation on June 21, 2010, at 9:48 a.m., in the resident room revealed, an oxygen concentrator in the on position delivering oxygen at 2L/MIN. Continued observation at this time revealed the nasal cannula tubing was dated June 11, 2010. Interview with Charge Nurse # 1 on June 21, 2010, at 10:15 a.m., in the resident room confirmed, the resident had recently received oxygen by nasal cannula (prior to breakfast this	F 328	The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.	

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F 328	Continued From page 2 morning) and the nasal cannula tubing dated June 11, 2010, was not changed weekly as facility policy states. Resident # 19 was admitted to the facility on June 20, 2005, with diagnoses including Alzheimer's Dementia, Hypertension, and Dyspnea. Medical record review of Recapitulation Physician's Orders for June 2010, revealed, " ...O2 (oxygen) at 3L/MIN (three liters per minute) PER (by) N/C (nasal cannula) PRN (as needed)..." Observation on June 21, 2010, at 9:52 a.m., in the resident room revealed, an oxygen concentrator in the on position delivering oxygen to the resident at 3L/MIN by nasal cannula. Continued observation at this time revealed the nasal cannula tubing was dated May 24, 2010. Interview with Charge Nurse # 1 on June 21, 2010, at 10:10 a.m., in the resident room confirmed the resident was receiving oxygen by nasal cannula and the nasal cannula tubing was dated May 24, 2010, and was not changed weekly as facility policy states. Review of the facility policy for Respiratory Equipment Change and Cleaning Guidelines revealed, " ...Nasal Cannula...Equipment Change...Weekly...Label with date changed..." Interview with the Director of Nursing (D.O.N.) in the facility business office on June 23, 2010, at 9:20 a.m., confirmed the facility policy for Respiratory Equipment Change was not followed.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	Continued From page 3 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of professional reference, and interview, the facility failed to appropriately administer medications in four of forty opportunities resulting in an error rate of ten percent. The findings included: Observation and interview of Licensed Practical Nurse (LPN #1) on hall 600 on June 22, at 8:45 a.m., 2010, revealed the nurse preparing medications at the medication cart. Observation included LPN #1 gathered the following oral medications for resident # 23: 1. Omeprazole 20 mg (milligrams) (medication to decrease gastric acid secretion); 2. Flomax 0.4 mg (to increase urination); 3. Multivitamin with Minerals (supplement); 4. Colace 100 mg (stool softener); 5. Potassium 20 millequivalents (replacement); 6. Prednisone 5 mg (steroid); 7. Furosemide 40 mg (diuretic); 8. Spironlactone 25 mg (antihypertensive); and 9. Celexa 40 mg (Anti-depressant). Continued observation revealed LPN #1 entered resident #23's room and placed the cup of medications on the table in front of the resident sitting in the chair. Continued observation and interview with resident #23 in the room on June 22, 2010, at 8:38 a.m., confirmed the breakfast	F 332	F332 The Residents found to be affected by this deficient practice were identified. No harm was observed in residents # 22, #23, #24 . Residents who have the potential to be affected by this deficient practice are all residents receiving medications. The nurses involved in the medication pass observation were individually counseled by the Director of Nursing (DON) or Staff Development Coordinator (SDC) regarding correct medication pass procedures. (06/23/10). Licensed Nursing staff to be inserviced by the SDC or DON on medication administration. Inservice will included medication administration prior to meal, with food and after meal. Also medication administration via G Tube with flushing before and after administration. (07/07/10 and ongoing) Medication administration will be included in the orientation of all new licensed nurses. 5) Competency testing for medication administration given to individual licensed nurses quarterly by the SDC or DON. Individual nurses will be retrained as needed by the SDC. An audit will be accomplished to identify residents 1) whose medications require administration is with food. 2) whose medication administration is via G Tube and require flushing. This audit procedure of staff training/testing and resident identification for observation to be collated by the DON for each 30 days, results reviewed/and reported to the PI (QA) Committee.	08/05/10

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F 332	Continued From page 4 meal had been served, consumed, and the tray had been removed from the room. Medical record review of the recapitulation of the Physician Orders dated June 1-30, 2010, revealed an order for Mucinex 600 mg (for treatment of chest congestion) twice a day (8A and 8P). Medical record review of the recapitulation of the Physician Orders dated June 1-30, 2010, revealed an order to administer the Omeprazole 20 mg before breakfast. Review of the medication book located at the nurses' station (2010 Pharmerica Specialized Long-term care nursing drug handbook) revealed the administration of Omeprazole is "Best if administered before breakfast." Interview with LPN #1 at the nurses' station on June 22, 2010, at 9:00 a.m., verified the Mucinex was omitted and the Omeprazole was administered after the meal. Observation on June 22, 2010, at 11:05 a.m., revealed Licensed Practical Nurse (LPN #2) preparing medications for administration to resident #22. Continued observation revealed the nurse prepared and gathered the medications and bolus feeding and entered the room. Continued observation revealed the nurse ascultated the abdomen via stethoscope; confirmed placement by positive "air bubbles;" and attached a syringe to the Gastrostomy tube to reveal no significant residual tube feeding. Continued observation revealed the nurse then administered the medications and bolus feeding via the G-tube.	F 332	The Director of Nursing, or designee, and/or the Pharmacist Consultant will conduct random medication pass reviews with licensed staff members at least weekly for three months then at least monthly and provide in-servicing and/or counseling as indicated. The DON, ADON or SDC will monitor through observation, Medication Administration Record review and Pharmacy Consultant report review, at least monthly for three months, then at least quarterly, to assure medications are administered according to physician orders and facility policy and procedure. The results of the medication review will be reported to the PI Committee each month as appropriate. Reporting to the PI committee will be accomplished/repeated each 30 days for a minimum of 90 days and/or until zero error reported. The Committee will review reports, make recommendations and instruct/give direction to assure compliance. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.	

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F 332	Continued From page 5 Interview with LPN #2 in the hallway on June 22, 2010, at 11:20 a.m., confirmed the medications and bolus feeding were administered without flushing the G-tube prior to administration. Review of the physician orders and Medication Record revealed, "Flush G-tube with water 15 ml (milliliters) before and after medications..." Interview with the Director of Nursing (DON) in the DON's office on June 23, 2010, at 9:30 a.m., confirmed the facility failed to follow the physician order to flush the G-tube prior to administration of medications. Observation and interview of LPN #3 on hall 400 on June 22, at 4:45 p.m., 2010, revealed the nurse preparing medications at the medication cart. Continued observation revealed LPN #3 gathered the following oral medications for resident # 24: 1. Ferrous Sulfate 325 mg (iron supplement); 2. Lotensin 20 mg (antihypertensive); 3. Requip 5 mg (antidepressant); and 4. Pepcid 40 mg (to treat ulcers). Continued observation revealed the medications were placed in a 30 cc (cubic centimeter) plastic medicine cup and two small spoonfuls of orange sherbet were placed on top of the medications. Continued observation revealed LPN #3 entered the room and administered the medications by two spoonfuls to the resident and then some water was consumed by the resident. Medical record review of the recapitulation of the Physician Orders dated June 1-30, 2010, revealed an order to give the Ferrous Sulfate 325	F 332		

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F 332	Continued From page 6 mg "with food." Interview in the conference room with the facility's Registered Dietician (RD #1) on June 23, 2010, at 8:35 a.m., revealed an order from the physician specifying a medication to be administered "with food" would indicate "a protein and a carb (carbohydrate)" to be given with the medication. Interview with the Director of Nursing (DON) in the DON's office on June 23, 2010, at 9:30 a.m., confirmed the facility failed to ensure a medication pass was performed with a medication error of less than 5 percent.	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F431 The bottle of Tuberculin Purified Protein Derivative was destroyed 06/22/10 No other bottles of medication were found open and not dated or opened and out of date. Residents found to be affected by the deficient practice were not identified. Residents who have the potential to be affected by this deficient practice will be identified by need for product usage. The Director of Nursing (DON) or Assistant DON or weekend RN supervisor will check the Med Room refrigerator daily for any opened and not dated vials (bottles) Any found opened and not dated will discarded and reported to the Center PI (QA) Committee. The DON or SDC will inservice the nursing staff on dating all bottles of medication upon opening for usage and disgarding according to manufacturer's instruction. (07/13/10 and ongoing)	08/06/10

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F 431	Continued From page 7 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's recommendations, and interview, the facility failed to assure biological are used or discarded prior to expiration for one of one medication rooms. The findings included: Observation of the refrigerator in the medication room on June 22, 2010, at 9:50 a.m., revealed one bottle of Tuberculin Purified Protein Derivative, ½ full, opened and not dated. Review of the manufacturer's instructions revealed, "Once entered, vial should be discarded after 30 days." Interview with the Director of Nursing (DON) in the DON's office on June 23, 2010, at 9:30 a.m., confirmed the facility failed to discard or use the biological prior to expiration.	F 431	Daily Audit by DON, ADON, SDC or Weekkend RN Supervisor with results reported and monitored through the Center PI (QA) Committee. The Committee will review reports, make recommendations and instruct/give direction to assure compliance. Reporting to the PI committee will be accomplished/repeated each 30 days for a minimum of 90 days and/or until zero error reported. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 8 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to change gloves during personal care for one (#2) of twenty-seven residents; and failed to	F 441	P441 1a) Resident found to be affected by the deficient practice (infection control-changing) was identified, #2. This resident was not on isolation precautions. The room of the resident #2 was cleaned/disinfected with attention given to all areas. All of the resident #2 linen was replaced with clean linen. 1b) Resident found to be affected by the deficient practice (infection control-medication administration) was identified, #24. No harm to this resident has been noticed. 2a) Residents who have the potential to be affected by this deficient practice would any resident using/receiving changing and peri-care. 2b) Residents who have the potential to be affected by this deficient practice would any resident using/receiving medication. 3a,b) The Staff Development Coordinator (SDC), Director of Nursing (DON) or Assistant DON (ADON) will inservice the nursing staff on Infection Control, proper gloving, changing and peri-care (07/01/10 and ongoing)and medication administration (Licensed only. 07/07/10 and ongoing). Nursing staff will receive competency testing on Infection Control procedures : proper gloving, changing and peri-care and medication administration. (Licensed only).by the SDC, DON.	08/05/10

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F 441	Continued From page 9 administer medications in a sanitary manner. The findings included: Observation of resident #2 on June 21, 2010, at 2:10 p.m., included personal care performed by Certified Nursing Assistant (CNA #1). Continual observation revealed CNA #1 gathered supplies, manipulated the bed controls located on the upper side rail of the bed to lower the head of the bed, and applied gloves to both hands. CNA #1 removed the covers from the resident and pulled back the disposable brief; and wiped the front of the pubis and perineal area with a wet washcloth. CNA #1 assisted the resident to roll onto the right side and removed the disposable brief. CNA #1 cleaned the buttocks and rectal area with a wet washcloth removing a small amount of fecal material. CNA #1 walked from the bedside to the closet and without changing gloves opened the door and obtained a disposable brief and returned to the bedside. CNA #1 applied clean linen and the clean brief before assisting the resident to roll onto the left side. Without changing the gloves, CNA #1 positioned the clean brief, assisted the resident to lay on the back; secured the brief; pulled the covers from the foot of the bed up onto the resident; secured the nasal cannula into the nostrils; manipulated the bed controls to raise the head of the bed; left bedside and touched the interior door handle to open the door to get a plastic bag. With the same gloved hands, CNA #1 with one hand held the roll of plastic bags in the mounted basket and with the other hand pulled two plastic bags from the roll; touched the exterior door handle to open the door; pushed the door closed; and gathered the linens and garbage and placed in the plastic	F 441	4) Infection Control Procedures will be monitored by the DON, ADON, SDC and Nursing Charge Nurses per shift. Discrepancies will be reported to the Infection Control Nurse and to the DON by the Charge Nurse. Personnel will be retrained if required by the SDC or DON. 5) Discrepancies will be reported to the Center PI (QA) Committee by the DON. The Committee will review reports, make recommendations and instruct/give direction to assure compliance Reporting to the PI committee will be accomplished/repeated each 30 days for a minimum of 90 days and/or until zero error reported. . The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING _____ B. WING _____	06/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH COUNTY HEALTH CARE CENTER	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 10 bags. Interview with CNA #1 in the hallway on June 21, 2010, at 2:21 p.m., verified the gloves were contaminated while performing personal care and were not changed before contaminating all the surfaces touched after personal care. Observation and interview of LPN #3 on hall 400 on June 22, at 4:45 p.m., 2010, revealed the nurse preparing medications at the medication cart for resident #24. Continued observation revealed LPN #3 dropped the medication Requip 5 mg (milligrams) (anti-depressant) onto the Medication Record page for resident #24. Continued observation revealed the LPN with bare fingers picked up the pill and placed it in the medicine cup with other medications. Continued observation revealed the LPN mixed the medications with orange sherbert and administered the medication to resident #24. Interview with the Director of Nursing (DON) in the DON's office on June 23, 2010, at 9:30 a.m., confirmed the facility failed to appropriately change gloves and failed to administer medications in a sanitary manner.	F 441		